



## FULL TIME NEW HIRE ENROLLMENT FORM

Name: \_\_\_\_\_ Location: \_\_\_\_\_

(Last Name, First Name, Middle Initial)

Home Address, City & Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Job Title: \_\_\_\_\_ First FT Working Day: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Salary: \_\_\_\_\_

Scheduled Hours per Week: \_\_\_\_\_ Pay Frequency: \_\_\_\_\_ Status: Full-Time

E-Mail Address: \_\_\_\_\_

### Please indicate below the insurance coverage you wish to select:

|                              |                |                |              |                 |
|------------------------------|----------------|----------------|--------------|-----------------|
| Medical Benefits (Base):     | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |
| Medical Benefits (Enhanced): | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |
| Dental Benefits (Base):      | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |
| Dental Benefits (Enhanced):  | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |
| Vision Benefits (Base):      | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |
| Vision Benefits (Enhanced):  | _____ Employee | _____ Emp. + 1 | _____ Family | _____ I decline |

(Emp. + 1 =

Emp. + Child(ren) or Emp. + Spouse)

If electing Family coverage for Health, Dental or Vision, please list your dependents below and **include verifying documentation** (recent tax return—black-out confidential information, birth certificate for children, marriage certificate for recent marriage, etc.). Please note that dependents will **not** be covered without their social security number.

| Name  | Social Security # | Gender | Date of Birth |
|-------|-------------------|--------|---------------|
| _____ | _____             | _____  | _____         |
| _____ | _____             | _____  | _____         |
| _____ | _____             | _____  | _____         |
| _____ | _____             | _____  | _____         |
| _____ | _____             | _____  | _____         |

Life Insurance: \$50,000 \_\_\_\_\_  
Employer Paid

Term Life & AD&D Buy-Up \_\_\_\_\_  
Up to 7x Salary or \$350,000, (Amount)  
(whichever is less without evidence of insurability -  
Employee Paid-Rate Based on Age of employee



**List Beneficiaries:**

| Name  | Relationship | SSN   | DOB   | Benefit % |            |
|-------|--------------|-------|-------|-----------|------------|
| _____ | _____        | _____ | _____ | _____     | Primary    |
| _____ | _____        | _____ | _____ | _____     | Primary    |
| _____ | _____        | _____ | _____ | _____     | Primary    |
| _____ | _____        | _____ | _____ | _____     | Contingent |
| _____ | _____        | _____ | _____ | _____     | Contingent |
| _____ | _____        | _____ | _____ | _____     | Contingent |

**Spouse Life Insurance:** Spouse Life & AD&D Buy-Up: \_\_\_\_\_  
(\$5,000 up to \$100,000 without \_\_\_\_\_ **(Amount)**  
evidence of insurability)  
Limit 50% of employee election - **Employee Paid—Rate Based on Age of employee**

**Dependent Child Life:** Dependent Life & AD&D Buy-up \_\_\_\_\_  
(\$25,000 - age over 6 months \_\_\_\_\_ **(Amount)**  
\$1,000 – age under 6 months) - **Employee Paid (\$5.00)**

**Short Term Disability:** Plan pays 65% of income after 7 consecutive days of disability.  
**Employer Paid** \_\_\_\_\_

**Long Term Disability:** \_\_\_\_\_ Base Plan \_\_\_\_\_ Buy-Up Plan  
Base Plan pays 40% of \_\_\_\_\_ Buy-Up pays 65% of \_\_\_\_\_  
Income after 90 days \_\_\_\_\_ Income after 90 days \_\_\_\_\_  
**Employer Paid** \_\_\_\_\_ **(Cost to you = \$21.00/month)**

**Flexible Spending Account (FSA):** \_\_\_\_\_ Annual Amount  
Maximum annual amount is \$3,200 (payroll deduction is required over 24 pays) - \$120 annual minimum

**Dependent Care Account (DCA):** \_\_\_\_\_ Annual Amount  
Maximum annual amount is \$5,000 (payroll deduction is required over 24 pays) - \$120 annual minimum

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits I selected above.

I understand these rates will remain in effect throughout the calendar year unless I experience a life-changing event or my employment is terminated with the Diocese of Columbus.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

